COMMISSION FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS
AUTHORIZATION TO REQUEST/RELEASE PATIENT PROTECTED HEALTH INFORMATION

Patient's Full Name _____ Birthdate _____ Social Security Number _____

1. AUTHORIZES: Name of Health Care Provider/Plan/Other:	2. RELEASE PROTECTED HEALTH INFORMATION TO: Name of Health Care Provider/Plan/Other:
Street Address:	Street Address:
City, State, Zip Code:	City, State, Zip Code:

I authorize the following protected health information (PHI) to be released:
[Specific description of portions of records to be released, i.e. clinic dictation, hearing tests, speech evaluations, physical/occupation therapy notes, nutrition notes, lab results, consultation, and *time periods of information to be released*]

_____

_____

_____

This is the minimum amount of information necessary for the purpose described above. No other information will be disclosed.

I understand that the information to be released includes (initial appropriate lines):

_____ Diagnoses and/or treatment _____ AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment

_____ HIV test results; _____ Diagnoses and/or treatment relating to other communicable diseases

Except as limited as follows: _____

This authorization for use/disclosure is for the following purpose(s): _____

_____

I understand that I do not have to sign this authorization and that the Commission for Children with Special Health Care Needs may not condition treatment or payment on whether I sign this authorization. However, I understand that I have the right to revoke this authorization, in writing, at anytime, and that the revocation will be effective except to the extent that the Commission for Children with Special Health Care Needs has already taken action in reliance on my authorization. I further understand that I may inspect or copy the PHI to be used or disclosed.

My written statement that I want to revoke my authorization should be delivered to:

[Name] _____ at [address] _____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information. I also understand that information used or disclosed pursuant to this authorization may result in direct or indirect remuneration from a third party.

This authorization expires on (please list a specific date or event) _____
or ninety (90) days from today's date (whichever occurs first) and will automatically become null and void without my express revocation.

I certify that I have received a copy of this authorization: _____
Individual/Guardian/Personal Representative Signature

Printed Name: _____ Date Signed: _____

If a personal representative on behalf of an individual has signed this authorization, his/her authority to act on behalf of the individual must be set forth here: _____

FOR OFFICE USE ONLY:

Staff person releasing information (signature): _____

(Date Information Released) _____ (Printed Name) _____